DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03-012

2. STATE: Nebraska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
August 13, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 438

7. FEDERAL BUDGET IMPACT:
a. FFY
b. FFY

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
List of Attachments, Page 1, 3
Section 4.13, Page 45(a) and 45(b)
Att. 2.2A, Page 10, 10a, 11
Section 3.1, Page 22
Section 4.29 Page 77
Section 4.18, Page 55
Section 4.14, Page 46, 50a
Section 4.30, Page 78a
Section 4.10, Page 41
Section 1.4, Page 9
Section 2.1 (b) page 11
Attachment 3.1-F, Pages 1-19
Attachment 4.30, Page 2, 3, 4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
List of Attachments, Page 1, 3
Section 4.13, Page 45(a) and 45(b)
Att. 2.2A, Page 10, 11
Section 3.1, Page 22
Section 4.29
Section 4.18, Page 55
Section 4.14, Page 46, 50a
Section 4.30, Page 78a
Section 4.10, Page 41
Section 1.4, Page 9
Section 2.1 (b) page 11
Att. 2-1A **DELETE**
Supplement 1 Att. 2.1-A, Pages 1-19 **DELETE**

10. SUBJECT OF AMENDMENT:
State Plan Changes Pursuant to BBA Medicaid Managed Care Regulation

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Governor has waived review

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Robert J. Seiffert

14. TITLE:
Administrator

15. DATE SUBMITTED:
September 19, 2003

16. RETURN TO:
Attn: Margaret Booth
HHS – F&S
P.O. Box 95026
Lincoln, Nebraska 68509

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 19, 2003

18. DATE APPROVED:
November 6, 2003

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
August 13, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
//Thomas W. Lenz-signature//

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Division of Medicaid and Children's Health

FORM HCFA-179 (07-92)

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6. A non-MCO contractors will act as enrollment brokers in assisting eligible recipients in choosing among competing health plans in order to provide recipients with more Information about the range of health care options open to them.

7. The state will share cost savings with recipients resulting from the use of more cost-effective medical care with recipients by eliminating co-payments for those who enroll into an MCO

8. The state requires recipients in PCCM to obtain services only from their assigned PCP or through referral to a Medicaid-participating provider who provides such services. Providers must meet reimbursement, quality, and utilization standards that are consistent with access, quality, and efficient and economic provisions of covered care and services. Recipients enrolled in MCO plans may be referred to any MCO-credentialed provider. The plan may also choose to allow non-emergency care to be provided by other practitioners on a case-by-case basis if it benefits the enrollee.

9. PCCM may operate in all counties of the state except in those geographical areas without an adequate number of primary care case managers participating in a PCCM. The MCO and PCCM program will operate in counties where MCOs have contracted with the state. Mandatory assignment will only occur if the recipient has a choice between at least two PCCM PCP or a combination of one MCO and the PCCM program.

10. Public process for proposed changes in the Nebraska MCO and PCCM programs. The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act. Public notice will be published in the Nebraska Register which is available to the public on a weekly basis. In addition ongoing public input is solicited through the Nebraska Medicaid Advisory Committee.

B. Assurances and Compliance

1. Consistent with this description, the state assures that all the requirements of Sections 1932, 1903(m), and 1905(t) of the Social Security Act will be met.

2. The NHC program Is available in selected counties in Nebraska. Mandatory enrollment provisions will not be Implemented unless a choice of at least two PCCM PCPs or a combination of MCO and the PCCM program is available.

3. Nebraska has safeguards in effect to guard against conflict of interest on the part of employees of the state and its agents.

4. Nebraska will monitor and oversee the operation of the mandatory managed care program, ensuring compliance with all federal program requirements, federal and state laws and regulations, and the requirements of the contracts agreed upon by Medicaid and its contractors.

5. Nebraska will evaluate compliance by review and analysis of reports prepared and sent to the Nebraska Medicaid agency by the contractors. Deficiencies in one or more areas will result in the contractor being required to prepare a corrective action plan, which will be monitored by the Nebraska Medicaid agency.

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6. Reports from the grievance and appeals process will be analyzed and used for evaluation purposes.

7. Nebraska staff will provide technical assistance as necessary to ensure that contractors have adequate information and resources to comply with all requirements of law and their contracts.

8. Nebraska staff will evaluate each contractor for financial viability/solvency, access and quality assurance.

C. Target Groups of Recipients

The NHC program is limited to the following target groups of recipients:

1. Families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act or related coverage groups.

2. Recipients eligible for Medicaid through the Medicaid expansion under the State Child Health Insurance Program (SCHIP). (Recipients in the Nebraska's separate SCHIP program are not enrolled in managed health care.)

3. AABD Adults

D. Mandatory Enrollment Exclusions

1. The following groups will not be enrolled in managed care:

   a. Clients with Medicare coverage pursuant to 471 NAC 3-000;

   b. Clients residing in nursing facilities and receiving custodial care pursuant to 471 NAC 12-000

   c. Clients residing in intermediate care facilities for the mentally retarded (ICF/MR) pursuant to 471 NAC 31 -000

   d. Clients who are residing out of state (Ie. Children placed with relatives out of state, and who are designated as such by HHSS personnel);

   e. Certain children with disabilities who are receiving in-home services, also known as the Katie Beckett program pursuant to 469 NAC 2-010.01 F;

   f. Aliens who are eligible for Medicaid for an emergency condition only pursuant to Titles 468, 469, 477, and 479 NAC.

   g. Clients participating in the refugee resettlement program/medical pursuant to Title 470 NAC;

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h. Clients receiving services through the following home and community based waivers pursuant to Title 480 NAC for:

1. Adults with mental retardation or other related conditions;

2. Aged persons, adults or children, with disabilities;

3. Children with mental retardation and their families;

4. Infants and toddlers with disabilities (a/k/a the Early Intervention Program;

5. Clients receiving Developmental Disability Targeted Case Management Services; and

6. Any other group for whom which the Nebraska HHS System has received approval of a 1915(c) waiver of the Social Security Act.

i. Clients who have excess income (i.e. spenddown - met or unmet) pursuant to 471 NAC 3-000;

j. Clients participating in the Subsidized Adoption Program, including those receiving subsidy from another state pursuant to Title 469 NAC

k. Clients participating in the State Disability Program pursuant to Title 469 NAC

l. Clients eligible during the period of presumptive eligibility pursuant to 471 NAC 28-000;

m. Transplant recipients pursuant to 471 NAC 10-000;

n. Clients who have received a specific disenrollment/waiver of enrollment from the Nebraska Medicaid Managed Care program.

o. American Indians and Alaskan Natives

p. Clients having other "qualified" insurance

q. Clients enrolled In another Medicaid Managed Care Program (except the PHP program)

r. Clients who have an eligibility program that is only retro-active.

E. Enrollment and Disenrollment

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1. All recipients will be given the opportunity to choose from at least two NHC providers. This will be multiple PCCM providers or a combination of PCCM providers and an MCO option or a choice of MCO's if two or more are available in a county. If a recipient has a prior provider relationship that they wish to maintain, the enrollment broker will assist the recipient in choosing a managed care entity that will maintain this relationship.

   Nebraska contracts with an independent contractor to conduct the enrollment process and related activities. The enrollment broker performs services and supplies information as follows to facilitate the enrollment process:

   a. Review provider access for each county quarterly to assure appropriate primary care access for the enrollees.

   b. Answer NHC-related questions from recipients and providers.

   c. Prepare enrollment materials for NHC program, for Department approval, and store NHC materials (MCO, PCCM and NHC in general).

   d. Process new enrollments and transfers for those NHC eligibles Identified by the Department.

   e. Process the recipient's choice of NHC option and send enrollments to the Department for inclusion on the next monthly medical card.

   f. Log grievances and requests for special authorization from NHC enrollees.

   h. Perform various quality assurance activities for the NHC program.

   i. Supply an enrollment packet to the recipients that includes MCO and PCCM materials and information supplied by the state and plans.

   k. Provides enrollment counseling which includes:

      (1) Inquiring about patient/provider experience and preference.

      (2) Providing information on which MCOs or PCCM PCPs are available to maintain a prior patient-provider relationship.

      (3) Facilitating direct contact with individual PCPS, PCCMs and MCOs, as necessary.

      (4) Providing any information and education concerning the enrollment process, individuals', benefits offered, the enrollment packet, client right's and responsibilities and any of the other information provided for in this section.

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1. If the recipient fails to choose an MCO or PCCM provider within a minimum of 45 calendar days after receiving enrollment materials, the Department assigns the recipient to a PCP in a PCCM or MCO.

2 Default enrollment will be based upon maintaining prior provider-patient relationships, proximity and prior familial/provider relationships.

3. Information in an easily understood format will be provided to beneficiaries on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered under the managed care arrangement, and comparative information among managed care entities regarding benefits and cost sharing, service areas, and quality and performance (to the extent available).

4. Any selection or assignment of an PCP, MCO or PCCM may be changed at any time, with the exception of pregnant woman who may only change plans within the first 90 days of enrollment or identification of their pregnancy if already enrolled (which ever is the latter) or upon good cause for the duration of the pregnancy plus 60 days.

5. Pregnant women will be provided notification 60 days before the end of a lock-in period of their opportunity to make a new choice of MCO or PCCM.

7. Enrollees will be given an opportunity to change PCPs, MCOs or PCCMs and will be sent a notice to that effect.

8. PCPs, MCOs and PCCMs will not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of services.

9. The MCO and PCCMs will not terminate enrollment because of an adverse change in the recipient's health.

10. An enrollee who is terminated from an PCP, MCO or PCCM solely because the enrollee has lost Medicaid eligibility for a period of two months or less will automatically be re-enrolled into the same MCO or PCCM upon regaining eligibility to the extent possible.

11. The recipient will be informed at the time of enrollment of the right to disenroll.

12. An enrollee will be allowed to choose his or her health professional in the MCO to the extent possible and appropriate and will be allowed to change his or her health professional as often as requested per the policy of the MCO. Changes made for good cause are not considered as a request for change if the MCO sets a number of changes allowed yearly.

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13. Enrollees will have access to specialists to the extent possible and appropriate and female enrollees will have direct access to women's health services.

F. Process for Enrollment in an MCO/PCCM

The following process is in effect for recipient enrollment in the NHC Program:

1. The Department shall provide beneficiaries with information in an easily understood format on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered under the managed care arrangement, and comparative information among managed care entities regarding benefits and cost sharing, service areas, and quality and performance (to the extent available).

2. All materials will be in an easily understood format (4th grade reading level or less). Materials will be translated into languages Spanish and Vietnamese, and other languages upon request, including braille.

3. Recipients will be able to select an MCO or PCCM from a list of available managed care entities in their service area. If the recipient wishes to remain with a PCP or plan with whom a patient/physician relationship is already established, the recipient is allowed to do so to extent possible. Each recipient shall notify the Department by mail, telephone or in person, of his or her choice of plans. If voluntary selection is not made within the 45 day period describe above, the NHC shall assign a PCP and a MCO or PCCM in accordance with the procedures outlined in E above.

4. As indicated in Section E, if the recipient does not choose a PCP , the Department will assign the recipient to a PCP and notify the recipient of the assignment.

5. The MCO and PCCM will be informed electronically of the recipient's enrollment in that plan.

6. The recipient will be notified of enrollment and issued an identification document.

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7. Additionally, each MCO will provide recipients the following information as soon as practicable after activation of enrollment:

   a. Benefits offered, the amount, duration, and scope of benefits and services available.

   b. Procedures for obtaining services.

   c. Names and locations of current network providers, including providers that are not accepting new patients.

   d. Any restrictions on freedom of choice.

   e. The extent to which there are any restrictions concerning out-of-network providers.

   f. Policies for specialty care and services not furnished by the primary care providers.

   g. Grievance and appeal process.

   h. Member rights and responsibilities.

G. Maximum Payments

The contract with the actuary requires that calculated rates shall be actuarially sound and consistent with generally accepted actuarial principles and practices as required by 42 CFR 438.6(c). State payments to contractors will comply with actuarial soundness in 42 CFR 438.6(c).

H. Covered Services

1. Services not covered by the NHC program will be provided under the Medicaid fee-for-service program. Medicaid recipients will be informed of the services not covered under the NHC Program, the process for obtaining such services. The State assures that the services provided within the managed care network and out-of plan and excluded services will be coordinated. The required coordination is specified in the state contract with MCOs and PCCMs and is specific to the service type and service provider.

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2. MCOs are directed to develop subcontracts or memoranda of understanding with federally qualified health centers (FQHCs) and rural health clinics (RHCs) as well as family planning clinics.

3. Preauthorization of emergency services and emergency post stabilization services and family planning services by the recipient's MCO is prohibited. Recipients will be informed that emergency and family planning services are not restricted under the NHC Program. "Emergency services" are defined in the MCO contract..

4. The PCCM shall be responsible for managing the services marked below in column (7). The MCO capitated contract will contain the services marked below in Column (4). All Medicaid-covered services not marked in those columns will be provided by the Nebraska Plan (under the requirements of that program) or Medicaid fee for service (without referral). Mental health and substance abuse treatment services are provided under the Nebraska Plan for Behavioral Health under the current 1915(b) waiver in effect for those services.

Service (1)	State Plan Approved (2)	MCO/PHP Capitated Reimburse ment (4)	Fee-for-Service Reimbursement Impacted by MCO/PHP (5)	Fee-for-Service Reimburse-ment for MCO/PHP (6)	PCCM Referral/ Prior Auth. Required (7)	Wraparound Service Impacted by PCCM (8)	PCCM Referral/Prior Authorization Not Required or Non-Waiver Services (9)
Day Treatment Services	x	X			X		
Dental	x			X			X
Detoxification	x						X
Durable Medical Equipment		x			X		
Education Agency Services	x			X			X
Emergency Services	x	X					
EPSDT	X	X			X		
Family Planning Services	x			X			X
Federally Qualified Health Center Services	x	X			X		
Home Health	x	X			X		
Inpatient Hospl - Psych	x			X			

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Service (1)	State Plan Approved (2)	MCO/PHP Capitated Reimbursement (4)	Fee-for-Service Reimbursement Impacted by MCO/PHP (5)	Fee-for-Service Reimbursement for MCO/PHP (6)	PCCM Referral/ Prior Auth. Required (7)	Wraparound Service Impacted by PCCM (8)	PCCM Referral/Prior Authorization Not Required or Non-Waiver Services (9)
Inpatient Hospital - Other	X	X			X		
Immunizations	X	X					X
Lab and X-ray for Medical Surgical Services	X	X			X		
Nurse Midwife	X	X			X		
Nurse Practitioner		X			X		
Nursing Facility				X			X
Obstetrical Services	X	X			X		
Occupational Therapy	X				X		
Other Fee-for-Service Services	X				X		
Other Psych. Practitioner	X			X			X
Outpatient Hospital - All Other	X	X			X		
Outpatient Hospital - Lab & X-ray for Medical Surgical Services	X				X		
Pharmacy	X			X			X
Physical Therapy	X	X			X		
Physician	X	X			X -		
Prof. & Clinic and Other Lab and X-ray	X	X					
Psychologist	X			X			X